

you have been unfortunate in one of these the third or fourth day after an operation, think this point over, "why did you lose the patient and why usually before the fourth day?" Is it because the patient is so much undernourished and run down that any additional load often results in infection which kills her? Plummer says that infection kills most of these patients. It is my experience and belief that the symptoms during the reaction clearly prove that infection has much to do with the high mortality in this type of surgery. Certainly there is no type that can cause the surgeon more worry for two or three days after the operation than thyroidectomy.

What are some of the advantages of local anesthesia? It enables one to feed the patient right up to the time of operation and to have practically no interruption following it. It gives the operator co-operation from the patient during the operation, making it possible for her to warn the operator when the recurrent laryngeal nerve is in danger or has been pinched. Many times I have been very close to this nerve, and have discovered my proximity to it by the disturbed breathing or changed voice of the patient. Again, a patient who is awake can co-operate with the surgeon by coughing, following the removal of the gland. This will dislodge a clot or poorly secured tie, and it will do this while the field is under the observation of the surgeon. Again, when one becomes thoroughly conversant with local anesthesia he has a tendency toward developing rapid technique because of the continual desire to get the patient off of the table as quickly as possible, a matter of great importance in this type of surgery. Shock, which is one of the important things not to be overlooked, is severe in direct proportion to the amount of trauma and anesthetic. We are extra careful to avoid shock when the patient is awake. It is true our mortality today, especially from exophthalmic goiter, has been much lowered through preparatory use of iodine, and we are losing very few patients. Certainly it should be our endeavor to lower our mortality still more.

CONCLUSIONS

1. Local anesthesia favors increased speed and efficiency of the operator and enforces gentleness in operations on the thyroid.
2. Small faint scars may be secured by: (a) short clean-cut incision; (b) free dissection of both the upper and lower flaps and laterally from the angles of the incision; (c) clean dissection and careful ligations; (d) small drain at angle instead of midline drain; (e) early removal of drain and skin clips; and (f) early and continued massage to keep skin from adhering in any place.

The essence of good manners, generosity of spirit, a sense of style and a sense of proportion, these are the essence of all art. They are the essence of the art of life. It is a tragic comment on our scurrying industrial society—and on the intellectual life it generates—that that most gracious of all arts is coming into disrepute.—Irwin Edman, *The Bookman*, August, 1926.

ADVANTAGES OF MEDICAL SOCIAL SERVICE IN ORTHOPEDIC SURGERY † •

By GEORGE J. MCCHESENEY *

MEDICAL Social Service is indispensable in the special field of orthopedic surgery. This is because orthopedic surgery is the surgery of chronic long-drawn-out diseases such as infantile paralysis, tuberculosis of bones and joints, spastic paraplegia, chronic arthritis and congenital deformities such as club-feet, dislocated hips, and cleft palate, in which services are required over a period of years, during which the medical social worker must maintain a proper contact between the surgeon and the patient. Essential contact consists not only in routine follow-up letters sent when the patient is overdue for the next visit, but in a periodic check-up of the changing financial status and social and housing conditions of the family. A child properly cared for at the beginning of a long course of treatment for tubercular hip or spine may later suffer from improper food and lodging when the father is out of work, or the family becomes larger as years pass by. Here is where steady visits and interviews by the social worker, with parents or patient, becomes so necessary, and is more often acceptable and, of course, more economical than too much attention by the doctor. A very helpful worker in these circumstances is the specially trained visiting nurse who can do simple dressings, inspect braces, shoes, plaster casts, recognize the kind of co-operation that is provided at home, the need of convalescent care in the country, etc., and report findings, actions, and changes of status to the physician.

An even more important service of the medical social worker is the assistance she can give in maintaining the morale of the patient and family. The encouraging ultimate prognosis that the orthopedist usually can give patients needs constant reiteration and amplification as time wears, and feasible results are slow in materializing. The surgeon, I fear, is apt to be impatient, often hurried, in his explanation for the general tediousness of things, and here the medical social worker can supplement her advice with additional details, information, and encouragement.

An important duty of social workers is the searching out and arranging for the treatment of hitherto unrecognized, missed or neglected patients requiring orthopedic care. Such patients are getting fewer with the many charitable agencies ferreting them out, but new ones are constantly being found and the search must continue as long as we have the ignorant, the poor, and tenement housing.

Another field of useful endeavor, the exact opposite of the foregoing, and in which the possibilities are but beginning to be recognized, is the social care and supervision after the period of active medical and hospital treatment is finished. These children,

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often handicapped by years of disease, are behind their fellows in school and need assistance and encouragement through the years up to maturity and a wage-earning status.

Lowman, in his Orthopedic Hospital School in Los Angeles, has recognized this need of bridging the gap between the periods of convalescence and wage earning by the formation of alumni clubs of former patients who have reunions once or twice a year, when they visit the hospital, have entertainments, etc. This gives them a chance to see and encourage patients undergoing treatment similar to their own, and also provides opportunity for the medical social worker to ascertain how the former patients are progressing and to aid them in getting jobs, keeping them off the streets, and to arrange for further treatment if necessary. In other words, this is a continuance of social care and supervision for years longer than formerly attempted, done under the guise of alumni associations, similar to the collegiate ones. The individual does not suspect the real purpose, which is to continue contact, with moral and material support after the medical is of secondary importance, and to continue until the person is a reasonable wage-earner, able to begin repaying his debt to the public which has hitherto provided for him. The economic value of this prolonged supervision is evident, for it bridges the long gap, usually several years between the end of medical treatment and the beginning of wage earning, and unless this is well and properly done the patient loses much, and the state is not reimbursed to the extent to which it is entitled. Many times possible pauperism and its heavy load upon the state may be prevented by this far-reaching after care.

This is but an outline of the many diverse duties of the medical social worker, duties requiring in the highest degree the qualities of common sense, tact, patience, and vision, by a group of health workers, often overworked, always underpaid. But in the larger and finer sense let them keep in mind George Francis Adams' lines: "He climbs highest who lifts another up."

Psychology is not yet a full-fledged science, but it has made important and far-reaching advances in the past few years. The behaviorists, the psychoanalysts, and the industrial psychologists are laying the basis for profound changes in the technic of group control. Where is this new knowledge being principally utilized at the present time? In the offices of advertising agencies. Today as never before the man with something to sell knows how to turn into cash three fundamental aspects of human nature: the desire to attract the opposite sex, the desire to exert power over one's neighbors, the desire to get safely and honorably to heaven. In brief, the higher salesmanship has captured applied psychology, horse, foot, and guns. And the very knowledge which might render us significant help is turned against us to create new wants, new desires, new forms of waste. (Some psychologist should write, as he starves, a monograph entitled: How to Build up Sales Resistance. No one will read it now, but in a hundred years he will have a statue in the market-place.)—Stuart Chase, Harper's, September.

HOW MEN DIE IN PRISON

By LEO L. STANLEY *

(From the California State Prison, San Quentin)

THERE always is much public curiosity about prisons and prisoners. The prison is the home of tragedy. Tragedy marks the crime, frequently attends the criminal throughout his life, and it is a tragic ending when he finds the iron doors locked behind him. Many tragedies, often fatal ones, are enacted within the prison walls.

How do men die in prison? This is a question which is worthy of a critical analysis. In the California State Prison at San Quentin, data for the past twenty-three years is available. The accompanying table, No. 1, shows the cause of death and the date, together with the prison population for each of these years. Chart I shows the prison population

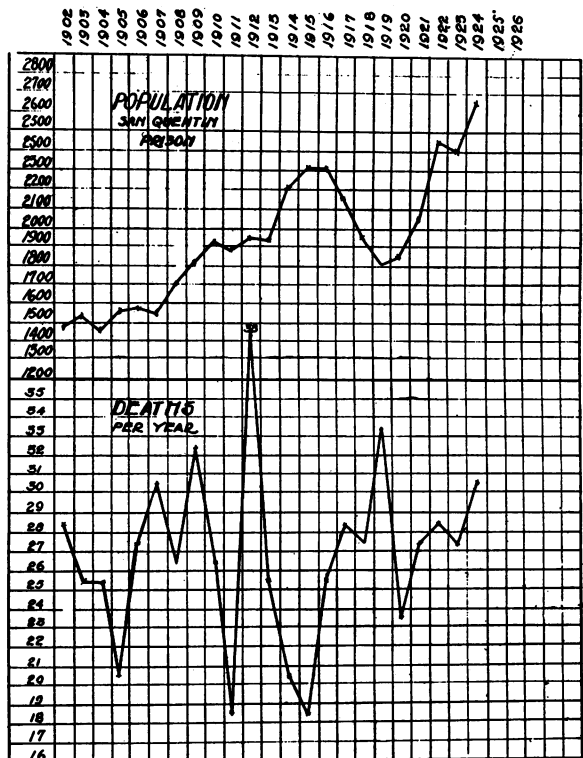


CHART I

by graph; Chart II shows the death rate per thousand from all causes, as well as the rate of death from tuberculosis and executions; Chart III shows the deaths per year by suicide; and Chart IV shows the number of deaths each year from tuberculosis and executions.

From Chart I it is seen that there has been a gradual increase of population in San Quentin from 1450 in 1902 to over 2600 in 1924. In 1916 the population began to decrease from 2230 until it reached 1800 in 1919. This was due to the fact that large numbers of young men were in the army. At

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